Sentara Health Plans

Commercial

Chiropractic Services, Medical 182

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Effective Date	8/1/2025
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Coverage Policy	Medical 182
Version	4

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details.

Description & Definitions:

Chiropractic Services is a type of alternative medicine that corrects the misalignment of joints, including the spine by hands on manipulative therapy and adjunctive treatment.

Criteria:

Chiropractic services are considered medically necessary for **1 or more** of the following:

- Rehabilitative chiropractic services are considered medically necessary for **all of** the following:
  - Services are delivered by a qualified provider of chiropractic services
  - Service is aimed at diagnosis, treatment, and/or prevention of disorders of the musculoskeletal system, and the effects of these disorders on the nervous system and general health
  - Service is for conditions that require the unique knowledge, skills, and judgment of a chiropractor for education and training of the individual that is part of an active skilled plan of treatment
  - There is a clinically supported expectation that the service will result in a clinically significant level of functional improvement within a ***reasonable and predictable period of time*** (see definition section) with **all of the** following:
    - An individual's function could not reasonably be expected to continue to be sustained or improved as the individual gradually resumes normal activities
    - The documentation objectively verifies progressive functional improvement over specific time frames and clinically justifies the initiation of continuation of rehabilitative services
  - Rehabilitative chiropractic service is for **1 or more** of the following:
    - Chiropractic spinal manipulation/mobilization (or grade V mobilization) to be medically necessary when **all** the following criteria are met:
      - There is adequate documentation that the individual has a symptomatic (acute, subacute, or chronic; with or without radicular components) musculoskeletal or related disorder attributable to a mechanical, structural, or functional disorder of the sacroiliac, lumbosacral; lumbar, thoracic and/or cervical spine or headache disorders including tension-type and migraine headaches
      - Area to be treated is 1 or more of the following spinal regions:
        - Cervical region (includes the atlanto-occipital joint)
        - Thoracic region (includes the costovertebral and costotransverse joints)
        - Lumbar region

        - Sacral region
        - Pelvic region (includes the sacro-iliac joints)
    - Documentation should include all of the following:
        - Absence of contraindications to spinal manipulation/mobilization in the area of treatment
        - Physical exam findings that correlate with the individual's subjective complaint(s) and support the diagnosis and treatment plan. Such findings may include 1 or more of the following:
            - Pain (e.g., bone, muscle, joint)
            - Tenderness/achiness (e.g., muscles, joints)
            - Stiffness and/or limited motion
            - Tone or texture changes in the adjacent muscles and soft tissues including muscle tightness or weakness
            - Asymmetry or misalignment between adjacent spinal segments
            - Acute inflammation (e.g., redness, heat, swelling, pain, impaired function, tenderness
            - Headache disorders (including tension-type and migraine headaches)
            - Impaired function (e.g., functional deficits, ADL restrictions)
            - Muscle disorders (e.g., spasms, cramps, injuries, trigger points)
            - Numbness/tingling or other paresthesia, weakness, loss of deep tendon reflexes, or other signs of nerve or nerve root compression or irritation
            - Other exam findings related and/or specific to the individual's condition(s) or complaint(s)
        - A valid musculoskeletal diagnosis for a spinal complaint for which there is sufficient clinical evidence that spinal manipulation/mobilization is both safe and efficacious.
        - Documentation that identifies against valid criteria (x-ray findings or physical exam findings) the presence and location of spinal dysfunctions / subluxation.
        - An assessment of clinically significant change(s) in the individual's condition(s) if documenting the need for continued care.
- Extra-Spinal Joint Manipulation/Mobilization is considered medically necessary for **all of the** following:
    - Area to be treated is 1 or more of the following extraspinal regions:
        - Head region (includes the temporomandibular joint, excluding the atlanto-occipital)
        - Upper extremities
        - Lower extremities
        - Rib cage (excluding the costotransverse and costovertebral joints)
        - Abdomen
    - Individual has no contraindications to services
    - Subjective complaint(s) and objective findings demonstrate a reasonable expectation of achieving a clinically significant level of improvement in the individual's complaint/condition. Complaints/conditions include, but are not limited to, 1 or more of the following:
        - Shoulder complaints, dysfunction, disorders, and/or pain
        - Restricted joint play of humeroradial joint
        - Restricted joint play of radiocarpal joint
        - Restricted joint play of iliofemoral joint
        - Restricted joint play of proximal tibiofibular joint
        - Ankle inversion sprains
        - Other reasonable/acceptable complaint/condition
    - Documentation should include all of the following:
        - The practitioner's clinical rationale to support extra-spinal manipulation/mobilization

- Abnormal joint mechanics or a range of motion abnormality that is appropriately documented and correlated with the subjective findings of an extra-spinal complaint and other pertinent exam findings in order to support extra-spinal manipulation/mobilization
- Physical exam findings that correlate with the individual's subjective complaint(s) and support the diagnosis and treatment plan. Such findings may include 1 or more of the following:
    - Pain (e.g., bone, muscle, joint)
    - Tenderness/achiness (e.g., muscles, joints)
    - Stiffness and/or limited motion
    - Tone or texture changes in the adjacent muscles and soft tissues including muscle tightness or weakness
    - Asymmetry or misalignment between adjacent spinal segments
    - Acute inflammation (e.g., redness, heat, swelling, pain, impaired function, tenderness
    - Headache disorders (including tension-type and migraine headaches)
    - Impaired function (e.g., functional deficits, ADL restrictions)
    - Muscle disorders (e.g., spasms, cramps, injuries, trigger points)
    - Numbness/tingling or other paresthesia, weakness, loss of deep tendon reflexes, or other signs of nerve or nerve root compression or irritation
    - Other exam findings related and/or specific to the individual's condition(s) or complaint(s)
- A valid musculoskeletal diagnosis for a spinal complaint for which there is sufficient clinical evidence that spinal manipulation/mobilization is both safe and efficacious.
- Documentation that identifies against valid criteria (x-ray findings or physical exam findings) the presence and location of spinal dysfunctions / subluxation.
- An assessment of clinically significant change(s) in the individual's condition(s) if documenting the need for continued care

- Chiropractic Spinal Manipulation/Mobilization on Children is considered medically necessary for all of the following:
    - Documentation establishes a valid diagnosis and symptom pattern and there is a reasonable assumption of a positive benefit versus risk profile. (***NOTE**: Additional caution should be considered prior to performing Chiropractic spinal manipulation on infants and children. While there is insufficient literature to conclude that CMT is clinically effective or ineffective in children, a limited, short trial of care may be reasonable when the CMT meets all other medical necessity criteria. Monitoring the individual's tolerance for the services provided and response to care is especially important in this population as tolerance and response is highly variable in the pediatric population.)

- Therapeutic modalities and procedures are considered medically necessary with all of the following:
    - Documentation should include all of the following:
        - Every treatment day and for each therapy performed. Each daily record should include all of the following:
            - Date of service
            - The name of each modality and/or procedure performed
            - The parameters for each modality (e.g., amperage/voltage, location of pads/electrodes)
            - Area of treatment
            - Total treatment time spent for each therapy (mandatory for timed services)
            - The total treatment time for each date of service
            - Identity of the person(s) providing the services
    - Modality or Procedure treatment intervention is 1 or more of the following:
        - Aquatic Therapy 97113 is considered medically necessary to develop and/or maintain muscle strength and range of motion when it is necessary to reduce the force of gravity through partial body immersion
        - Activities of Daily Living training is considered medically necessary to enable the individual to perform essential activities of daily living and self-care including bathing, feeding, preparing meals, toileting, dressing, walking, making a bed, and transferring from bed to chair, wheelchair, or walker

- Cold Packs are considered medically necessary for musculoskeletal conditions that include significant pain and or swelling
- Contrast baths is considered medically necessary to reduce hypersensitivity reduction and swelling
- Diathermy (shortwave) 97024 is considered medically necessary for pain relief, increased circulation, and muscle spasm reduction when individual does not have any contraindications including all of the following:
    - No metal in the treatment area or on the body
    - No cancerous tissues
    - No hemorrhagic conditions
    - No acute inflammatory or injury
    - No pregnancy
    - No cardiac pacemakers
    - No other contraindications to treatment
- Electrical muscle stimulation is considered medically necessary for muscle re-education (to improve muscle contraction) in the earlier phases of rehabilitation
- Gait Training is considered medically necessary for individuals whose walking abilities have been impaired by neurological, integumentary, muscular or skeletal abnormalities, surgery, or trauma. This also includes crutch/cane ambulation training and re-education.
- Hot Packs are considered medically necessary for musculoskeletal conditions that include significant pain and or swelling
- Hydrotherapy/Whirlpool/Hubbard Tank is considered medically necessary for pain relief, muscle relaxation and improvement of movement for persons with musculoskeletal conditions or for wound care (cleansing and debridement).
- Iontophoresis 97033 is considered medically necessary for the treatment of inflammatory conditions, such as plantar fasciitis and lateral epicondylitis
- Infrared light therapy 97026 is considered medically necessary when there is a contraindication to other forms of heat. Utilization of the Infrared light therapy CPT code is not appropriate for low level laser treatment
- Mechanical Traction is considered medically necessary for all of the following:
    - When there is no improvement after the application of other evidence-based therapeutic procedures to significantly improve symptoms for 3 weeks
    - The individual has signs of nerve root compression or radiculopathy
    - It is used in combination with other evidence-based treatments including therapeutic exercise with extension movements
- Neuromuscular reeducation 97112 is considered medically necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident, and systemic neurological disease. Example techniques may include: proprioceptive neuromuscular facilitation (PNF), BAP's boards, vestibular rehabilitation, desensitization techniques. This does not include contract/relax or other soft tissue massage techniques. NMR is typically used as the precursor to the implementation of Therapeutic Activities
- Orthotic Training 97760/97763 is considered medically necessary when the documentation specifically demonstrates that the specific knowledge, skills, and judgment of a Chiropractor are required to train the individual in the proper us of braces and/or splints (orthotics). Many braces or splints do not require specific training by the Chiropractor in their use and can be safely procured and applied by the individual. Individuals with cognitive, dexterity, or other significant deficits may need specific training where other individuals do not.
- Paraffin Bath 97018 is considered medically necessary to relieve pain and increase range of motion of extremities (typically wrists and hands) in post-surgical individuals or individuals with chronic joint dysfunction.
- Prosthetic Checkout assessments are considered medically necessary when a device is newly issued or there is a modification or re-issue of the device. These assessments may also be considered medically necessary when an individual experiences loss of function directly related to the orthotic or prosthetic device (e.g., pain, skin breakdown, or falls). This is usually completed in 1-2 sessions.
- Prosthetic Training is considered medically necessary when the professional skills of the practitioner are required to train the individual in the proper fitting and use of a prosthetic (an

artificial body part, such as a limb). Periodic return visits beyond the third month may be necessary
- Soft Tissue Mobilization is considered medically necessary for treatment of pain and restricted motion of soft tissues resulting in functional deficits
- Therapeutic Activities is considered medically necessary after an individual has completed exercises focused on strengthening and range of motion but needs to improve function-based activities.
- Therapeutic exercise is considered medically necessary to restore/develop strength, endurance, range of motion and flexibility which has been lost or limited as a result of a disease or injury.
- Therapeutic Massage is considered medically necessary when performed to restore muscle function, reduce edema, improve joint motion, or relieve muscle spasm caused by a specific condition or injury.
- Ultrasound is considered medically necessary to relieve pain and improve healing during the acute phase of treatment
- Wheelchair Management Training is considered medically necessary only when it is part of a broader active treatment plan directed at a specific goal. The individual must have the capacity to learn from instructions. Typically, three (3) sessions are adequate

Rehabilitative Chiropractic Services are NOT COVERED for ANY of the following:

- Chiropractic Services maintenance care (e.g., elective care, wellness care)
- Spinal manipulation/mobilization for non-musculoskeletal conditions
- The service is not aimed at diagnosis, treatment, and prevention of disorders of the musculoskeletal system, and the effects of these disorders on the nervous system and general health
- The service is for conditions for which therapy would be considered routine educational, training, conditioning, or fitness. This includes treatments or activities that require only routine supervision
- The expectation does not exist that the service(s) will result in a clinically significant improvement in the level of functioning within a reasonable and predictable period of time (up to 4 weeks) including all of the following:
    - If function could reasonably be expected to improve as the individual gradually resumes normal activities, then the service is considered not medically necessary
    - If an individual's expected restoration potential would be insignificant in relation to the extent and duration of the service required to achieve such potential, the service(s) would be considered not medically necessary
    - The documentation fails to objectively verify functional progress over a reasonable period of time (up to 4 weeks)
    - The individual has reached maximum therapeutic benefit
- A passive modality is not preparatory to other skilled treatment procedures or is not necessary in order to provide other skilled treatment procedures safely and effectively
- A passive modality has insufficient published evidence to support a clinically meaningful physiologic effect on the target tissue or improve the potential for a positive response to care for the condition being treated
- Services do not require the skills of a qualified provider of chiropractic services. Examples include but not limited to all of the following:
    - Practitioner recommended activities and services that can be practiced independently and can be self-administered safely and effectively
    - Home exercise programs that can be performed safely and independently to continue therapy without skilled supervision
    - Activities for the general health and welfare of the individual such as 1 or more of the following:
        - General exercises (basic aerobic, strength, flexibility, or aquatic programs) to promote overall fitness/conditioning.
        - Services/programs for the primary purpose of enhancing or returning to athletic or recreational sports
        - Massages and whirlpools for relaxation
        - General public education/instruction sessions
- Reevaluations or assessments of an individual’s status that are not separate and distinct services from those work components included within the Chiropractic Manipulative Services
- Reevaluations or assessments of an individual’s status that are not necessary to continue a course of therapy nor related to a new condition, new or changed health status for which the evaluation will likely result in a change in the treatment plan.
- Service is non-medical, educational, or training in nature. In addition, these treatments/programs may be specifically excluded under benefit plans including 1 or more of the following:

- Back school
- Group therapy (because it is not one-on-one, individualized to the specific individual's needs).
- Vocational rehabilitation programs and any program or evaluation with the primary goal of returning an individual to work
- Work hardening programs
- Nutrition wellness education or similar wellness interventions

Chiropractic spinal manipulation chiropractic services for non-musculoskeletal and related disorders in children are NOT COVERED for ANY of the following conditions:

- Asthma
- Infantile colic
- Nocturnal enuresis
- Otitis media

Therapeutic modalities and procedures are NOT COVERED for ANY of the following:

- Axial/Spinal decompression Therapy (aka Decompression Therapy or Spinal Decompression Therapy)
- Dry needling
- Electrical muscle stimulation (except neuromuscular electrical stimulation [NMES]) in an area with sensory deficits (decrease or loss)
- Low Level Laser therapy
- Manual muscle testing to diagnosis non-neuromusculoskeletal conditions
- Microcurrent Electrical Nerve Stimulation (MENS)
- Microwave diathermy
- Redundant Therapeutic Effects and Duplicative Rehabilitative Services by Different Healthcare Practitioners/Specialties including all of the following:
  - Overlapping functional activities and ADLs
  - More than one heating modality
  - Massage therapy and myofascial release
  - Orthotics training and prosthetic training
  - Whirlpool and Hubbard tank
  - CMT and manual therapy techniques applied for same physiological purpose
- Therapeutic exercises when exercising is done by the individual within a clinic facility or other location (e.g., home; gym) without a physician or therapist present and supervising

Therapeutic modalities and procedures using superficial heat are NOT COVERED for ANY of the following contraindications:

- Individual has open wounds or damage from radiation in the treatment area
- Individual has allergies to paraffin
- Individual has an inability to communicate or respond to pain
- Individual has impaired sensation in the treatment area or have unreliable thermoregulation, (such as the very young or very old)
- Individual has cancer, thrombophlebitis, hemorrhage, fever, peripheral vascular disease, cardiac insufficiency, edema, or severe inflammation in the treatment area
- Individual has a bleeding disorder
- Individual is pregnant, if the treatment area is near the developing fetus

Therapeutic modalities and procedures using deep heat modalities are NOT COVERED for ANY of the following contraindications:

- Pregnancy (over the abdomen or low back)
- Active bone growth at epiphysis
- Cancerous tissues (over a known or suspected malignancy)
- Tuberculosis infection
- Hemorrhagic conditions (over area of active bleeding)
- Impaired circulation (pulsed ultrasound is not contraindicated)
- Cardiac pacemaker or defibrillator
- Acute inflammation or injury
- Metal (e.g., implants, surgical staples)

There is insufficient scientific evidence to support the medical necessity of chiropractic services for uses other than those listed in the clinical indications for procedure section.

Document History:

Revised Dates:

- 2024: September – criteria updated references updated2022: June

Reviewed Dates:

- 2025: Implementation date of August 1, 2025. No changes to criteria. Updated format only.
- 2023: October

Origination Date: July 2021

Coding:

Medically necessary with criteria:

Coding	Description
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97026	Application of a modality to 1 or more areas; infrared
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;

	A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes.
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes.
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes.
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions.
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions.
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions.
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions.
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation.
E0855	Cervical traction equipment not requiring additional stand or frame.
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.
L0626	Lumbar orthosis (LO), sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.
L0627	Lumbar orthosis (LO), sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.

L0631	Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.
L0637	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.
L0650	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf.

Considered Not Medically Necessary:

Coding	Description
20561	Needle insertion(s) without injection(s); 3 or more muscles.
97016	Application of a modality to 1 or more areas; vasopneumatic devices.
97150	Therapeutic procedure(s), group (2 or more individuals).
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure).
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure).

E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories.

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to Products: Policy is applicable to Sentara Health Plan Commercial products.
- Authorization Requirements:
    - Pre-certification by the Plan is required.
- Special Notes:
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Federal Register. National Archives. Retrieved 4.17.2025. https://www.federalregister.gov/documents/search?conditions%5Bterm%5D=chiropract

US Food and Drug Administration. SUPPLEMENT 2: CHIROPRACTIC SYSTEMS ABOVETABLE X-RAY SOURCE RADIOGRAPHIC SYSTEMS (Test procedure ARB - Use form FDA 2784). 4.1.2000. Retrieved 4.17.2025. https://www.fda.gov/media/75987/download

Hayes. A symplr Company. Chiropractic Treatment for Low Back Pain. Health Technology Assessment. Annual Review: 12.14.2009. Retrieved 4.17.2025. https://evidence.hayesinc.com/report/dir.chir0001

Centers for Medicare and Medicaid Services. CMS.gov. Chiropractic Services. L37254. 2.6.2025. Retrieved 4.17.2025. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=37254&ver=15

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Practitioner . Revision Date: 12/2/2022 Appendix D: Service Authorization Information. Retrieved 4.17.2025. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/Physician-Practitioner%20Manual%20App%20D%20%28Updated%2012.2.22%29_Final.pdf

Commonwealth of Virginia. Department of Medical Assistance Services. Service Authorization Process for EPSDT (Assistive Tech, Chiropractic, Orthotics, Hearing Aids) Revised 7-7-2023. Retrieved 4.17.2025. https://vamedicaid.dmas.virginia.gov/sites/default/files/2024-06/_EPSDT%20%28Assistive%20Tech%20Chiropractic%20Orthotics%20Hearing%20Aids%29_Revised.pdf

National Comprehensive Cancer Network. Retrieved 4.17.2025. https://www.nccn.org/search-result?indexCatalogue=nccn-search-index&searchQuery=chiropracter

Carelon Guidelines. Retrieved 4.17.2025. https://guidelines.carelonmedicalbenefitsmanagement.com/?s=chiropract&et_pb_searchform_submit=et_search_proccess&et_pb_include_posts=yes&et_pb_include_pages=yes

The American College of Physicians (ACP). Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. 2.14.2017. Retrieved 4.17.2025. https://www.acpjournals.org/doi/10.7326/M16-2367

PubMed. Song, Y. P., Liu, J. L., Zong, C. Z., Zhang, F. S., Ren, Y. F., Ching, Y. L., Wang, Y. X., Li, W. X., Zhao, H., Huang, Y. R., & Gao, K. (2024). A bibliometric study on trends in chiropractic research from 1920 to 2023. Complementary therapies in medicine, 82, 103038. Retrieved 4.17.2025. https://doi.org/10.1016/j.ctim.2024.103038

MCG Informed Care Strategies. 28th Edition. 2024. Spinal Manipulation Therapy (SMT), Chiropractic and Other. ACG: A-0331 (AC). Retrieved 4.17.2025. https://careweb.careguidelines.com/ed28/index.html

Keywords:

SHP Chiropractic Services, SHP Medical 182 Commercial, SHP Medical 182, Chiropractic Services, Rehabilitative Services, Habilitative Services, Therapeutic Modalities, Aquatic Therapy, Activities of Daily Living, Cold packs, Contrast bath, Diathermy, Electrical stimulation, Gait training, Hydrotherapy, Whirlpool, Hubbard tank, Iontophoresis, Infrared light therapy, Mechanical traction, Neuromuscular reeducation, Orthotic training, Paraffin bath, Prosthetic training, Soft tissue mobilization, Massage, Back school, Work hardening program, Spinal decompression, Decompression therapy, Axial decompression, Dry needling, Acupuncture, Spinal manipulation, Spinal mobilization, Cervical, Thoracic, Lumbar, Extra-spinal joint manipulation, Extra-spinal joint mobilization, Spinal pain, Joint stiffness, Limited joint motion, Paresthesia, humeroradial joint, radiocarpal joint, iliofemoral joint, proximal tibiofibular joint, Ankle inversion sprains, Hot Packs, Prosthetic Checkout, Therapeutic Activities, functional activities, Therapeutic exercise, Wheelchair Management Training, Maximum Therapeutic Benefit, Electrical muscle stimulation, neuromuscular electrical stimulation, Low Level Laser therapy, Manual muscle testing, Microcurrent Electrical Nerve Stimulation, Microwave diathermy, Rehabilitative chiropractic services, Chiropractic spinal manipulation, Chiropractic spinal mobilization, grade V mobilization, sacroiliac, lumbosacral, cervical spine, headache disorders, tension-type headaches, migraine headaches, atlanto-occipital joint, costovertebral joint, costotransverse joint, pelvic region, musculoskeletal, proprioceptive neuromuscular facilitation, BAP's boards, vestibular rehabilitation, desensitization techniques